GUIDE TO
MARYLAND MEDICAL CARE PROGRAM
COVERAGE GROUPS

Version August 2012

A coverage group is a group of people who meet specific criteria to receive Medical Assistance (also known as Medicaid or MA) or other benefits through Maryland's Medical Care Programs. Recipients in most coverage groups receive a red and white Medical Care Program card, unless otherwise indicated in this narrative. There are many ways for people to qualify for medical care benefits (for example, by being a recipient of Supplemental Security Income (SSI) or meeting technical and financial tests for Medical Assistance, Qualified Medicare Beneficiary (QMB), or Primary Adult Care Program (PAC). Sometimes the only difference between coverage groups is a single criterion. For example, children under 1 year old are in one group, while those between 1 and 6 years old are in another. Families whose income is within the medically needy income limit are in one group, and those with income exceeding the limit (spend-downs) are in another. Consequently, there are many different coverage group codes to describe how recipients qualify for benefits.

There are 68 coverage group codes in MMIS-II. Each coverage group is identified by a code--one letter designating the "track," followed by two numbers (e.g., F01). Some coverage group codes are assigned to recipients by CARES as part of an eligibility determination. Other codes originate with the Department of Health and Mental Hygiene (DHMH), to identify recipients enrolled in programs that are not included in CARES. Generally, users do not need to know all 68 coverage groups, but should be familiar with the tracks (the alpha designation for coverage groups).

A track is a group of related coverage groups. There are 11 tracks. The same basic eligibility rules are used for all coverage groups in the same track (as in the families and children "F" track), or all groups within the track share a common characteristic (as in the "E" track, which includes all children covered based on placement in foster care or subsidized adoption). Knowing the basic requirements for each track enables the user to quickly understand a recipient's enrollment in a particular coverage group.

The most frequently used tracks are for families and children (FAC) (F-track), low income pregnant women and children in the Maryland Children's Health Program (MCHP) (P-track) and aged, blind, or disabled individuals (ABD) (S-track). Long term care (LTC) cases have their own tracks, one for ABD individuals (L-track) and another for children and Temporary Cash Assistance (TCA) adults (T-track).

Several coverage groups have few, if any, recipients, such as the FAC LTC spend-down group (T99). This is for a child in LTC, who has monthly income so high that it exceeds the LTC facility's cost of care, and places the child in spend-down. While this rarely occurs, the group is needed because it is covered under the State Plan.

Some groups included in this Guide are obsolete or otherwise no longer used, such as D01 and D03 for the MCHP Premium Employer-Sponsored Insurance groups. CARES will not allow cases to be enrolled in these groups, and MMIS will not accept current certifications. However, the codes are maintained, with historic descriptions here, because payments and reporting may still be required for prior enrollments.

Coverage Group Definitions

The following is a brief description of each of the coverage groups under MMIS-II. The attached "Quick Reference Guide to Medical Care Program Coverage Groups and HealthChoice Eligibility" may be a more convenient desk reference. Unless noted, the code for each group is the same in CARES and MMIS.

These descriptions do not include all of the eligibility criteria for each group, but are intended to familiarize the user with the coverage groups. This Guide is purely descriptive and does not establish or change policy or procedures, which are specified in official sources. Because of the brevity of these descriptions, they cannot be used as accurate and complete representations of eligibility requirements.

Maryland Children's Health Program (MCHP) Premium - D-Track

(D-Track effective 7/01/01)

See COMAR 10.09.43 and the MCHP Premium Eligibility Manual for the D-track's policies and procedures for eligibility determinations.

Effective 1/1/07: D02 and D04 MCHP Premium coverage groups were added to Maryland's Medicaid Expansion CHIP program, leaving Maryland with no stand-alone CHIP coverage.

Effective 7/1/04:

- D02 and D04 MCHP Premium coverage groups opened to new enrollments after being frozen for 7/1/03 – 6/30/04.
- The P14 coverage group transferred back to MCHP after being in MCHP Premium for 9/1/03 – 6/30/04.

Effective 7/1/03:

- Employer-sponsored insurance (ESI) was discontinued as an MCHP Premium enrollment option. Children enrolled in ESI plans (D01 or D03) were transferred to HealthChoice (D02 or D04) at the end of their insurance plan's benefit period.
- The Children's Health Program under Title XXI of the Social Security Act provides **federally enhanced match** to cover uninsured children under the age of 19 whose income is above 200% of the federal poverty level (FPL) but at or below 300% of the FPL.
- Children are certified in a D-track MCHP Premium coverage group only if they fail to qualify for coverage in P-track MCHP coverage groups.
- MCHP Premium coverage requires that the family pay a premium. Eligibility does not begin until the premium is paid and an MCO is selected.
- Since eligibility for MCHP Premium is determined at DHMH, the coverage groups are only found on MMIS, not on CARES.
- Recipients in D02 and D04 receive their medical care through HealthChoice, Maryland's Managed Care Program. These recipients differ from other HealthChoice enrollees because they cannot receive fee-for-service benefits prior to their enrollment with a managed care organization (MCO).
- This group receives a HealthChoice card from the MCO they select, as well as a red and white Medical Care Program card for certain services not covered by the MCO. These two cards allow them to be covered for all Medicaid State Plan services.

D01 Discontinued 7/1/03: Employer-Sponsored Insurance (ESI) 200% - 250% FPL

Medical care services for D01 recipients were provided through employer-sponsored insurance (ESI). This enrollment option was discontinued effective 7/1/03, and existing enrollees were enrolled in HealthChoice at the end of their ESI benefit year.

D02 MCHP Premium 200% - 250% FPL

Children younger than 19 years old are enrolled in D02 if their parent or other caretaker relative is willing to pay the monthly premium and if their household income is above 200% and at or below 250% of the FPL. Medical care services for D02 recipients are provided through HealthChoice.

D03 Discontinued 7/1/03: Employer-Sponsored Insurance (ESI) 250% - 300% FPL

Medical care services for D03 recipients were provided through ESI. This enrollment option was discontinued effective 7/1/03, and existing enrollees were enrolled in HealthChoice at the end of their ESI benefit year.

D04 MCHP Premium 250% - 300% FPL

Children younger than 19 years old are enrolled in D04 if their parent or other caretaker relative is willing to pay the monthly premium and if their household income is above 250% and at or below 300% of the FPL. Medical care services for D04 recipients are provided through HealthChoice. Because the family income is higher than for the D02 group, the premium is higher.

Foster Care & Subsidized Adoptions - E-Track

There are no income or resource tests for these groups. See Policy Alerts 03-8 and 03-9 for a description of the policies and procedures for eligibility determinations and redeterminations for these coverage groups of children receiving foster care or subsidized adoption services through the Department of Human Resources (DHR). See Policy Alert 10-13 for a description of independent foster care adolescents added to the E02 coverage group pursuant to state law enacted in 2009.

E01 Title IV-E or SSI, Foster Care or Subsidized Adoption

Federally matched Medical Assistance is provided to a foster care or subsidized adoption child who receives Supplemental Security Income (SSI) or is determined eligible for assistance under Title IV-E of the Social Security Act.

E02 Non-Title-IV-E, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship

Federally matched Medical Assistance is provided to non-IV-E foster care children who meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Children eligible for subsidized adoption and subsidized guardianship are also included in this group if they are technically eligible for Medical Assistance and have special needs for medical, mental health, or rehabilitative care. Effective

1/1/2003, independent foster care adolescents not eligible for federal (IV-E) benefits but eligible for state benefits were permitted to retain MA coverage, without regard to income, until age 21. Effective 10/1/2009, independent foster care adolescents up to 21 who are not eligible for federal (IV-E) or state foster care extension can retain or reinstate MA subject to a disregard of income between 116% and 300% FPL.

E03 State Funded Foster Care

The State funds Medical Assistance coverage for children in foster care who are not IV-E or SSI eligible and do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Since this is not a federal category, children in this group may not be enrolled in HealthChoice or Rare and Expensive Case Management (REM).

E04 State Funded Subsidized Adoption & Subsidized Guardianship

The State funds Medical Assistance coverage for children in State subsidized adoption and subsidized guardianship who are not IV-E or SSI eligible and either do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number) or do not have special needs for medical, mental health, or rehabilitative care. Since this is not a federal category, children in this group may not be enrolled in HealthChoice or REM.

Families and Children (FAC) - F-Track

The F-track is for eligible families with dependent children and for other eligible children under the age of 21. Families consist of parent(s) (biological, step or adoptive) or other caretaker relatives and unmarried children living with them. An eligible pregnant woman also constitutes a family (*i.e.*, an assistance unit of at least 2).

F01 Temporary Cash Assistance (TCA) Recipients - Section 1931

Federally matched Medical Assistance is automatically provided to children and families approved for Temporary Cash Assistance (TCA), even if their cash benefit amount is $0. Effective October 1, 1996, federal welfare reform abolished the Aid to Families with Dependent Children (AFDC) program and replaced it with Temporary Assistance for Needy Families (TANF). Section 1931 of the Social Security Act permits states to adopt Medical Assistance (MA) rules that are more liberal than the 1996 AFDC rules. Maryland adopted more liberal MA rules in order to match the rules for TCA, Maryland's TANF program. See DHR's TCA Manual and COMAR 07.03.03 for the policies and procedures for determining TCA eligibility.

F02 Post TCA and MA Extension Due to Earned Income (Transitional MA)

Federally matched Medical Assistance is provided to F01/F05 families who were receiving Medical Assistance for at least 3 of the previous 6 months and lose Medical Assistance eligibility due to income from new employment, increased hours of employment, or the loss of an earned income disregard. Effective 1/1/2010, families receive Transitional Medical Assistance for 12 months from the month of closure.

F03 Post TCA and MA Extension Due to Child or Spousal Support (Transitional MA)

Federally matched Medical Assistance is provided to F01/F05 recipients who were receiving Medical Assistance for at least 3 of the previous 6 months and lose Medical Assistance eligibility due to over-scale income from increased collections of child or spousal support. Eligibility in this group is limited to 4 months from the month of the closure.

F04 Discontinued 7/1/08: TCA Closed or Denied Due to Non-MA Requirement - Section 1931

Federally matched Medical Assistance was provided to persons who lost or were denied eligibility under F01 and TCA because they failed a non-financial TCA requirement that was not a requirement of Maryland's Medical Assistance (e.g., failed to meet a TCA work requirement), but who were otherwise qualified for TCA.

F05 Families and Children – Section 1931

Effective 7/1/08, federally matched Medical Assistance is provided to families with dependent children and pregnant women whose countable household income is within the new effective income standard of 116% of the FPL. Neither applicants nor recipients are required to verify their income. Assets (resources) are not considered. [Prior to 7/1/08, the effective income standard was equivalent to the TCA standard, assets were considered, and applicants and recipients were required to verify their income.]

F98 Families and Children - Medically Needy - Non-Spend-down

Federally matched Medical Assistance is provided to families with dependent children, caretaker relatives, pregnant women and children under age 21 who are not eligible for categorically needy groups, whose income is under the effective income standard of 116% of the FPL and whose assets are within the medically needy asset standards. Effective 12/1/2009, legal permanent residents aged 19 and 20 who have been in the U.S. less than 5 years (but are no longer barred from Medicaid) are being entered in F98 for tracking purposes. All other individuals will not be "found eligible" for F98 but may pass through this coverage group to the F99 spend-down coverage group.

F99 Families and Children - Medically Needy – Spend-down

Effective 7/1/08, families with dependent children, caretaker relatives, pregnant women, and children under age 21 who are not eligible for categorically needy groups and whose resources (assets) are within the MA medically needy standard, but whose income exceeds 116% of the FPL, qualify for federally matched Medical Assistance when they spend-down their excess income within the certification period/period under consideration. That is, they become eligible when their incurred medical expenses equal the amount of income that exceeded the income standard. **Individuals eligible under MA spend-down may not be enrolled in HealthChoice.**

Refugees - G-Track

Aliens who are classified as refugees, asylees, or victims of severe trafficking may be covered for Medical Assistance services in the G-track for the first 8 months after either their month of U.S. entry as a refugee or their effective month of asylum or victim of severe trafficking status. See DHR FIA Manual Release 04-01 with the attached "Refugee Cash Assistance and Refugee Medical Assistance Manual." See also DHR FIA Action Transmittals 11-31 and 02-85, "Increase in Eligibility Standards for RMA" and CARES Bulletin 06-02, "Refugee Medical Assistance."

G01 Refugee Cash Assistance (RCA)

Federally matched medical care coverage under TCA Section 1931 is provided to all persons determined eligible for Refugee Cash Assistance by a refugee resettlement center.

G02 Post RCA Extension Due to Earnings, Hours, Loss of Disregard

Federally matched medical care coverage is provided for the first 4 months to persons who lose RCA coverage (G01) due to over-scale income resulting from increased earnings or hours of employment or the loss of earned income disregards.

G98 Refugee Medical Assistance (RMA) - Non-Spend down

Federally matched medical care coverage is provided to refugees, asylees, and victims of severe trafficking who are not receiving RCA and are technically ineligible for federal Medical Assistance as FAC, ABD, or MCHP recipients (e.g., do not meet the requirements for citizenship or eligible alien status). The income requirements for G98 were changed as of 10/1/01 from the MA medically needy standard to a standard that is less than or equal to 200% of the federal poverty level (FPL). Resources must be within the MA medically needy standard.

G99 Refugee Medical Assistance (RMA) – Spend-down

Federally matched medical care coverage is provided to refugees, asylees, and victims of severe trafficking who are not receiving RCA and are technically ineligible for federal Medical Assistance as FAC, ABD, or MCHP recipients. Their resources must be within the MA medically needy standard. If their income exceeds the income standard for G98, they qualify for federally matched coverage when they spend-down their excess income within the period under consideration when their incurred medical expenses equal the amount of income that exceeded the income standard. Individuals eligible under spend-down may not be enrolled in HealthChoice.

Home & Community Based Services Waivers and PACE - H-Track

The purpose of a home and community based services waiver, also known as a "1915(c) waiver," is to enable children or aged, blind, or disabled adults to be maintained in their homes or community settings rather than in a medical institution.

- Services for waiver participants are treated as federally matched expenses, although these services are not included in the State Medicaid Plan.
- Each waiver program has different medical and other non-financial criteria for its targeted population.

- Income and resources are evaluated for the applicant/recipient as a household of one person, as if the individual were institutionalized and separated from the family unit. Other long-term care rules may be applied for financial eligibility, including spousal impoverishment and look-back for disposal of resources for less than fair market value. If the recipient is placed in an out-of-home community-based facility, the recipient may be assessed a client contribution to pay towards the cost of care.
- Besides being covered for all Medical Assistance State Plan services, waiver participants receive certain services that are only available to individuals enrolled in that particular waiver program. This enables the program to provide appropriate medical and supportive services without institutionalizing the individual.
- Waiver participants, except those in the Model Waiver for Disabled Children, are enrolled in HealthChoice if they are eligible (e.g., not elderly or dually enrolled in Medicare and MA).
- There is a COMAR chapter with policies specific to each waiver program.

Maryland has nine home and community-based services (HCBS) waiver programs: Waiver for Children with Autism Spectrum Disorder; Model Waiver for Disabled Children; Waiver for Older Adults; Living at Home: Maryland Community Choices (also known as Waiver for Adults with Physical Disabilities or Attendant Care Waiver); Model Waiver for Adults with Traumatic Brain Injury; Medical Day Care Services Waiver; Psychiatric Residential Treatment Facilities (PRTF) Waiver; and two waiver programs for individuals with developmental disabilities, Community Pathways and New Directions (effective 7/1/05). In addition to the regulations and manuals cited above, information about waiver programs appears in Policy Alert 10-10, its Supplement, and Policy Alert 10-11.

H01 Home and Community Based Services (HCBS) Waivers and PACE

For persons meeting an HCBS waiver's specific medical and other non-financial criteria, certain financial eligibility rules are waived or changed for the special waiver eligibility group. Income may not exceed 300% of the SSI federal benefit rate, and resources are capped at $2,000.

Effective November 1, 2002, federally matched Medical Assistance is provided to individuals at least 50 years old who qualify for the Program of All-Inclusive Care for the Elderly (PACE) as a State Plan option. The same Medical Assistance eligibility rules are used for PACE as for HCBS waivers. The PACE provider receives monthly capitation from both Medicare and Medical Assistance for all medical and supportive services received either in the home and community or in medical institutions (including long-term care facilities).

H98 Discontinued: Home and Community Based Services (HCBS) Waiver - Medically Needy – Non-Spend-down

For persons who met the medical and other non-financial criteria for the Older Adults Waiver, but who failed the resources test, eligibility was established by meeting the MA community medically needy resource and income standards. Financial eligibility was determined as if the person were living separately from the family unit. There was no spend-down for income.

H99 Coverage group not in use: Home and Community Based Services (HCBS) Waiver

Aged, Blind or Disabled (ABD) Long Term Care (LTC) – L-Track

L01 SSI-Only Recipient in Long Term Care

Federally matched Medical Assistance is provided to cover the cost of care in long term care facilities for adults and children whose sole income source is Supplemental Security Income (SSI) (coverage group S02 in the community). Their other medical services are also covered. Institutionalized SSI recipients are made eligible for L01 if they have no income besides their SSI benefit. If they have other income to contribute towards their cost of care, the children are determined eligible in coverage group T02 and the adults in L98.

L98 ABD Long Term Care

Federally matched Medical Assistance is provided to cover a portion of the cost of care in long term care facilities, for aged, blind or disabled persons whose available income is insufficient to meet the entire cost in the long term care facility. The resource limit is $2,500. Other medical services are also covered.

L99 ABD Long Term Care – Spend-down

Federally matched Medical Assistance is provided to aged, blind or disabled persons if their available income exceeds the cost of care in a long term care facility, but they have other incurred medical expenses that exceed their excess available income. The resource limit is $2,500. Medical Assistance does not cover cost of care in the long term care facility, but does cover other medical services that are not used for spend-down.

Pregnant Women and Maryland Children's Health Program (PW/MCHP) – P-Track

The P-track covers eligible children under 19 years old and pregnant and postpartum women. MCHP Title XIX includes coverage groups P01 through P12; coverage groups P13 and P14 are in MCHP Title XXI (along with the D-track MCHP Premium coverage groups). There is no resource test for these groups. See COMAR 10.09.11 and the MCHP Eligibility Manual for the policies and procedures for determining MCHP eligibility.

P01 Discontinued 7/1/1997: General Public Assistance to Pregnant Women

Pregnant women who were ineligible for AFDC because they were not in their last trimester, and who were eligible for GPA-PW (State-only cash assistance), were granted federally matched Medical Assistance. This coverage group was discontinued in July 1997 due to the changes in welfare reform.

P02 Pregnant Women Up to 200% of the Federal Poverty Level (FPL)

Federally matched Medical Assistance coverage is provided to pregnant women whose household income is at or below 200% of the FPL. This coverage continues for the postpartum period, until the end of the 2nd month following the end of the pregnancy.

P03 Newborns of Eligible Mothers

Federally matched Medical Assistance coverage is provided to children under 1 year old if the child's mother was covered by Medical Assistance for the child's date of birth (including a mother covered retroactively or as an alien in the X-track). Since these newborns are deemed eligible based on the mother's eligibility, an application is not necessary. This group also includes children who are certified by DHMH based on documentation of birth received directly from the hospital or managed care organization (1184 process). This group does not include newborns of P11 mothers (see P11 and P12).

P04 Discontinued 7/1/98: Medically Needy Newborns

Federally matched Medical Assistance coverage was provided to children under one year old if the child's mother was receiving Medical Assistance as a medically needy person at the time of the child's birth. Effective 7/1/98, CARES and MMIS no longer accept current certifications in this group, as these newborns are now included in the P03 coverage group.

P05 Discontinued 7/1/97: Newborns of Women Who Would be Eligible if Still Pregnant

Federally matched Medical Assistance was provided to children under 12 months old who reside with their mothers, if their mothers were receiving Medical Assistance at the time of birth and would still be receiving Medical Assistance if they were pregnant. Effective 7/1/98, CARES and MMIS no longer accept current certifications in this group, as these newborns are now included in the P03 coverage group.

P06 Child Under 1 Year Old, Up to 185% of the Federal Poverty Level

Federally matched Medical Assistance coverage is provided to children who are under 1 year old and whose household income is at or below 185% of the FPL, if the child is not deemed eligible for P03.

P07 Child Age 1 Up to 6 Years Old, Up to 133% of the Federal Poverty Level

Federally matched Medical Assistance coverage is provided to children who are at least 1 year old but less than 6 years old, if their household income is at or below 133% of the FPL.

P08 Child Under 19 Years Old, Up to 100% of the Federal Poverty Level

Federally matched Medical Assistance coverage is provided to children up to their 19th birthday, if their household income is at or below 100% of the FPL.

P09 Discontinued 7/1/98: Maryland Kids Count Waiver

Children born after 9/30/83 whose family income exceeded the standards for full-benefit Medical Assistance under Pregnant Women and Children (PWC) received limited coverage for outpatient services in this coverage group. Children with family incomes up to 200% of FPL are now eligible for full benefits in the CHIP coverage groups P13, and P14.

P10 Medicaid Family Planning Program (MFPP)

Women eligible for coverage group P02 are automatically covered for **family planning services** when their P02 MCHP eligibility ends after their postpartum period. This program is federally matched through a waiver. Since coverage is initiated at DHMH, this group is found on MMIS, not on CARES. Effective 1/1/12, the Maryland Medicaid Family Planning Program expansion provides services to women under 51 years of age with income at or below 200% of the federal poverty level (FPL). Women who are not pregnant must submit an application to determine eligibility for MFPP. The MFPP covers services related to birth control only. This program does not cover abortion services or prenatal care. These individuals receive a **purple and white card.**

P11 Pregnant Women, 200% - 250% of the Federal Poverty Level

Federally matched Medical Assistance coverage is provided to pregnant women whose household income is above 200% and at or below 250% of the FPL. Except for the higher income level, the eligibility and coverage for this group is identical to P02. This coverage continues for the postpartum period, until the end of the 2nd month following the end of the pregnancy.

P12 Newborns of P11 Mothers

Federally matched Medical Assistance coverage is provided to children under 1 year old, if the child's mother was covered as a P11 for the child's date of birth, including retroactively. This group also includes children who are certified by DHMH based on documentation of birth received directly from the hospital or MCO (1184 process).

P13 MCHP (Title XXI) – Child Under 19 Years Old, Up to 185% of the Federal Poverty Level

An enhanced federal match under the Maryland Children's Health Program (MCHP) provides medical coverage to uninsured children up to their 19th birthday. They do not qualify as P07 or P08 because their household income exceeds the limit for those coverage groups. Their household income is at or below 185% of the FPL. This group has an additional eligibility requirement that the recipient may not be covered by employer-sponsored health insurance, and may not have voluntarily dropped such insurance within 6 months prior to application.

P14 MCHP (Title XXI) – Child Under 19 Years Old, 185%-200% of the Federal Poverty Level

Effective 7/1/04, this coverage group is returned to MCHP from being in MCHP Premium for 9/1/03 – 6/30/04. **An enhanced federal match** under the Maryland Children's Health Program (MCHP) provides medical coverage to uninsured children under the age of 19 whose household income is above 185% and at or below 200% of the FPL. Children are certified in this coverage group only if they fail to qualify for coverage as P13 due to household income that exceeds 185% of the FPL. This group has an additional eligibility requirement that the recipient may not be covered by employer-sponsored health insurance, and may not have voluntarily dropped such insurance within 6 months prior to application.

Aged, Blind, or Disabled (ABD), Medicare Savings Program, S-Track

S01 Public Assistance to Adults - PAA

Federally matched Medical Assistance is provided to persons who are recipients of Public Assistance to Adults (PAA), a State-funded program administered by the Department of Human Resources (DHR). PAA provides grants to support ABD adults in out-of-home, community-based residences (Project HOME adult foster care, certain assisted living facilities, and Mental Hygiene Administration residential rehabilitation programs). Included in this coverage group are persons who do not receive a PAA benefit because of recoupment, the grant is less than $10, or the case is suspended. See DHR's COMAR 07.03.07 for the eligibility policies and procedures specific to PAA.

S02 Supplemental Security Income (SSI) Recipients

Federally matched Medical Assistance is provided, without a separate MA application and without an annual MA redetermination, to all SSI recipients for as long as the U.S. Social Security Administration categorizes them as SSI recipients. This group includes persons who do not receive an SSI check but whom the Social Security Administration still deems SSI eligible, such as Disabled Adult Children (DACs) (see Policy Alert 03-3), Disabled Widowed Beneficiaries (DWBs) (see Policy Alert 03-4), and certain non-elderly disabled or blind individuals who lose SSI benefits due to employment. For the federal SSI eligibility policies and procedures, see Title 20 of the U.S. Code of Federal Regulations (CFR). DACs receive notice of their status from Social Security, while DWBs must apply. The DWB benefit ends at age 65.

S03 Qualified Medicare Beneficiaries (QMB)

Persons who are eligible for Medicare receive federally matched Medical Assistance coverage of their **Medicare Part B (Medical Insurance) premiums, as well as coverage of their co-payments and deductibles for services covered under Medicare. Medicare Part A (Hospital Insurance) premiums** are also covered if the individual is not entitled to free coverage due to insufficient qualifying working quarters. For QMB eligibility, income of the applicant (or applicant and spouse) must be at or below 100% of the federal poverty level, and resources may not exceed three times the SSI standard. QMB resources are also subject to a $1500 burial allowance and a disregard for the value of life insurance policies. These individuals receive a **gray and white QMB card.**

S04 Pickle Amendment

Federally matched Medical Assistance is provided to persons who meet the criteria specified in the federal law known as the "Pickle Amendment". These are persons who would be eligible for SSI except that their Social Security benefits increased as the result of an annual cost of living adjustment and caused them to exceed the income standard for SSI eligibility. See AT 00-12.

S05 Section 5103 Eligibles

Persons eligible in this coverage group lost SSI eligibility because a change in the federal disability definition enabled them to qualify for Social Security benefits. Federally matched Medical Assistance is provided to these persons if they would be eligible for SSI except for the

fact that the Social Security cash benefit causes them to exceed the SSI income standard.

S06 Qualified Disabled and Working Individuals (QDWI)

Non-elderly persons who are entitled to Medicare Part A (Hospital Insurance) by reason of their disability, but who are not eligible to receive a Social Security benefit because they are employed, may be eligible for federally matched Medical Assistance coverage of their **Medicare Part A premiums** if their income is at or below 200% of the federal poverty level and their resources do not exceed twice the SSI standard. **A card is not issued** for QDWI recipients since the benefit does not cover any medical services.

S07 Specified Low Income Medicare Beneficiaries (SLMB)

Medicare recipients are eligible for SLMB I if they have income above 100% of the FPL (the QMB income limit) but less than 120% of the FPL. The SLMB resource standard is the same as for QMB--three times the SSI standard. Their resources are also subject to a $1500 burial allowance and a disregard for life insurance policies. These individuals are eligible for federally matched Medical Assistance coverage of only their **Medicare Part B premiums**. **A card is not issued** for SLMB recipients, since the benefit does not cover any medical services.

S08 Discontinued 6/1/06: SLMB and Maryland Pharmacy Assistance Program (SLMB/MPAP)

Persons who were eligible for both SLMB (see S07) and the Maryland Pharmacy Assistance Program (see S09 history) were assigned a single coverage group code on MMIS. S08 was generated by MMIS, while these recipients continued to appear as S07 on CARES. With the implementation of Medicare Part D between 1/1/06 and 5/15/06 for pharmacy coverage of Medicare beneficiaries, SLMB recipients in coverage group S08 were moved to S07 on MMIS when their enrollment in a Medicare prescription drug plan was confirmed by DHMH.

S09 Primary Adult Care Program (PAC) (effective 7/1/06)

Primary Adult Care Program (PAC): Beginning 7/1/06, the Maryland Pharmacy Assistance Program was combined with the Maryland Primary Care Program to create the Primary Adult Care Program. The program covers primary care, outpatient specialty mental health services and pharmacy benefits furnished through PAC Managed Care Organizations (separate from HealthChoice MCOs) and authorized under a Medicaid demonstration waiver (also called a "§1115 waiver"). Effective 1/1/10, substance abuse services and the facility costs of Emergency Room visits were added to the PAC benefits. To be eligible, an individual or couple must be at least 19 years old, not eligible for Medicare, not institutionalized, and not claimed as a dependent by a parent for income tax purposes. As of 4/1/09, to be eligible for services under the PAC program, income must not exceed 116% of the federal poverty level (FPL) for a household of one person or a couple; and there is no resource test. To be considered for PAC eligibility, individuals must submit a separate application to the PAC Program. Since PAC certifications are made at DHMH using an independent eligibility system, PAC recipients are on MMIS but **not** on CARES. These individuals receive a **yellow and white PAC card.**

Discontinued 6/30/06: Maryland Pharmacy Assistance Program (MPAP). Beginning 10/1/02, persons who were ineligible for MA and MCHP could apply for coverage of **prescription medications through MPAP**. Effective 1/1/06, Medicare beneficiaries could no

longer participate in the Medicaid-funded MPAP because pharmacy services became available to them under Medicare Part D. Effective 7/1/03, the income limit changed to 116% of the FPL for a household of one person and 100% of the FPL for larger households. The resource limit was twice the SSI standard for a one or two person household ($4,000 or $6,000). Since MPAP certifications were made at DHMH, these recipients were on MMIS and not on CARES. MPAP participants received a **yellow and white MPP card.**

S10 Discontinued 6/1/06: QMB and MPAP

Beginning on 10/1/02, all Qualified Medicare Beneficiaries (QMB) (see S03) were automatically enrolled by DHMH in MPAP (see S09 history). They were assigned to coverage group S10 on MMIS. With the implementation (1/1/06 to 5/15/06) of Medicare Part D pharmacy coverage for Medicare eligibles, QMBs in coverage group S10 were moved to S03 when their enrollment in a Medicare prescription drug plan (PDP) was confirmed by DHMH.

S11 Discontinued 7/1/06: Transitional Emergency, Medical and Housing Assistance (TEMHA) and MPAP

Coverage group S11 was generated by MMIS to identify TEMHA (now TDAP) recipients who were enrolled in MPAP. Enrollees in the Temporary Disability Assistance Program (TDAP) who qualify for PAC are now in the S09 coverage group on both MMIS and CARES. These recipients appear as "GA" on CARES.

S12 Discontinued 7/1/*06: Family* Planning Program (FPP) and MPAP

With the implementation of the Primary Adult Care (PAC) Program (see S09) on 7/1/06, women eligible for both FPP and PAC were permitted to enroll in one program or the other but not both concurrently. Previously, women who were eligible for both FPP and MPAP (see P10 and S09) could participate in both and were assigned a single coverage group code in MMIS.

S13 Accelerated Certification of Eligibility

Individuals are temporarily placed in this coverage group when they have been granted an accelerated certification, pending final determination in a different coverage group.

S13-D Employed Individuals with Disabilities Program (EID) (effective 4/1/06)

Effective October 1, 2008, the Employed Individuals with Disabilities Program (EID) was expanded to permit individuals with disabilities throughout the state to be eligible for Medical Assistance coverage and remain in the workplace. The EID program began on 4/1/06 as a waiver program that provided buy-in to Medical Assistance for a limited number of individuals with disabilities who would otherwise not qualify due to earnings.

Individuals who qualify for EID are covered on a fee-for service basis for full Medical Assistance benefits, with the exception of services in long-term care facilities, Rare and Expensive Case Management, the PACE program and certain home and community-based waivers. Individuals must pay a monthly premium to participate in EID. Individuals qualify for EID if they are 18-64 years old, are employed or self-employed, have been determined disabled by the Social Security Administration, receive Social Security Disability Insurance (SSDI) or lost SSI or SSDI solely due to employment, have income no more than 300% of the FPL, and

have resources no more than $10,000. For individuals who have a 401(k), 403(b), pension plan or Keogh plan, the individual's ownership interest is excluded from the aggregate current cash value when determining the resource amount.

In order for the individual to be considered for eligibility, the individual has to submit a separate application to the EID Program. EID certifications are made by the DHMH Division of Eligibility Waiver Services (DEWS). This coverage group is on MMIS, not on CARES. EID recipients receive the **red and white Medical Care Program card.**

The "D" distinguishes EID recipients from recipients placed in the S13 group for temporary certification pending final determination in a different coverage group.

S14 Specified Low Income Medicare Beneficiaries II (SLMB II) (Qualifying Individual 1—QI-1)

Individuals whose income is at least 120% but less than 135% of the federal poverty level, and whose resources do not exceed three times the SSI standard, disregarding $1500 as a burial allowance and cash value of any life insurance, qualify for federally matched Medical Assistance coverage limited to their **Medicare Part B premiums**. **A card is not issued** for these recipients since the benefit does not cover any medical service. This group is distinguished from SLMB I only by a higher income standard and an enhanced federal match for state expenditures.

S15 Discontinued 12/31/02: Specified Low Income Medicare Beneficiaries III (SLMB III) (Qualifying Individual 2—QI-2)

This group was discontinued effective 12/31/02 when the federal government stopped funding this category of benefits. The QI-2 population included individuals whose income was at least 135% but less than 175% of the federal poverty level and whose resources did not exceed twice the SSI standard. These beneficiaries received federally matched payment toward a portion of the Medicare Part B premium in the form of an annual check. **No card was issued** as no medical services were covered.

S16 Increased Community Services Program (ICS)

Beginning January 1, 2012, Maryland opened a demonstration program to provide Medicaid-covered services in home and community-based settings rather than in nursing facilities for individuals eligible for MA-LTC, who would be ineligible due to excess income when tested under community rules. This demonstration is, like Maryland's HCBS waiver programs, subject to a cap on the number of participants. Resources are capped at $2,500.

Discontinued 1/1/06: Maryland Pharmacy Discount Program. The Maryland Pharmacy Discount Program (MPDP) ended on 1/1/06 with the implementation of Medicare Part D pharmacy coverage. MPDP was implemented on 7/1/03, under the authority of the HealthChoice Medical Assistance demonstration waiver. At that time, the waiver allowed the creation of the Maryland Pharmacy Program (MPP), consisting of MPAP and new MPDP. MPDP helped Medicare beneficiaries with income at or below 175% of the FPL to pay for **prescriptions** covered by the Medical Assistance Program. There was no resource test. Recipients paid 65% of the MA price for the prescription, as well as a $1 processing fee to the pharmacy. To be considered for MPDP eligibility, the individual had to submit a separate

application to the Maryland Pharmacy Program. Since MPDP certifications were made at DHMH, these recipients were on MMIS but not on CARES. These individuals received a **yellow and white MPP card**.

S17 Discontinued 1/1/06: SLMB I and Maryland Pharmacy Discount Program (SLMB I/MPDP))

When MPDP ended on 1/1/06 with implementation of Medicare Part D, recipients in coverage group S17 on MMIS were reassigned to S07. Previously, beginning 7/1/03, persons who were eligible for both SLMB I (see S07) and the Maryland Pharmacy Discount Program (see S16) were assigned to coverage group S17 on MMIS. Since S17 was generated by MMIS, these recipients appear as S07 on CARES.

S18 Discontinued 1/1/06: SLMB II (QI-1) and Maryland Pharmacy Discount Program (SLMB II/MPDP)

When MPDP ended on 1/1/06 with implementation of Medicare Part D, recipients in coverage group S18 on MMIS were reassigned to S14. Previously, persons who were eligible for both SLMB II (see S14) and the Maryland Pharmacy Discount Program (see S16) were assigned to coverage group S18 on MMIS. Since S18 was generated by MMIS, these recipients appear as S14 on CARES.

S98 ABD Medically Needy – Non-Spend-down

Federally matched Medical Assistance is provided to aged, blind, or disabled persons whose income and resources (including those of their spouse living with them) are within the MA community medically needy income and resource standards.

S99 ABD Medically Needy – Spend-down

Aged, blind, or disabled persons, whose resources are within the MA community medically needy resource standard but whose income exceeds the medically needy income standard, qualify for federally matched Medical Assistance within the period under consideration when they spend-down their excess income—i.e., when their incurred medical expenses equal the amount of income that exceeded the income standard. Individuals eligible under MA spend-down may not be enrolled in HealthChoice.

Families and Children Long Term Care - T-Track

See Policy Alert 03-10 for a description of policies and procedures for eligibility determinations and redeterminations for these long-term care coverage groups.

T01 TCA Adult or Child in Long Term Care

When an adult or child receiving TCA (coverage group F01) is placed in a long-term care facility (LTCF), federally matched Medical Assistance will pay the cost of care in the facility and cover their other medical services.

T02 FAC Child in Long Term Care

Federally matched Medical Assistance is provided for a child under 21 years old (as a household of one) who resides in a LTCF, if the child's income is insufficient to pay the LTCF's cost of care. Otherwise, the FAC rules for the F-track are used for consideration of income. Medical Assistance will pay the portion of the cost of care in the facility that exceeds the child's available income, and will cover their other medical services. **There is no resource test.**

T03 MCHP Child Under 1 Year Old in Long Term Care

Federally matched Medical Assistance is provided for a child under 1 year old with income **at or below 185% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay the child's available income towards the cost of care in the LTCF. Otherwise, eligibility rules for P06 are used. **There is no resource test.**

T04 MCHP Child From 1 Year Old Up to 6 Years Old in Long Term Care

Federally matched Medical Assistance is provided for a child who is at least 1 year old but less than 6 years old with income **at or below 133% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay the child's available income towards the cost of care in the LTCF. Otherwise, eligibility rules for P07 are used. **There is no resource test.**

T05 MCHP Child Under 19 Years Old in Long Term Care

Federally matched Medical Assistance is provided for a child under 19 years old with income **at or below 100% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay the child's available income towards the cost of care in the LTCF. Otherwise, eligibility rules for P08 are used. **There is no resource test.**

T99 FAC Child in Long Term Care – Spend-down

Children under 21 years old who reside in a LTCF, whose resources do not exceed the medically needy resource standard for a household of one person, but whose available income exceeds the cost of care in the LTCF, are eligible for federally matched Medical Assistance if they have other incurred medical expenses that exceed the excess available income. Medical Assistance does not pay towards the cost of care in the LTCF but does cover the child's other medical services.

Women's Breast or Cervical Cancer - W-Track (Effective 4/01/02)

W01 Women's Breast and Cervical Cancer Health Program (WBCCHP)

Federally matched Medical Assistance is provided to women aged 40-64, who are diagnosed with breast or cervical cancer, need treatment, and are uninsured (or whose insurance does not cover cancer treatment). Eligible women must be screened through the Maryland Breast and Cervical Cancer Screening Program. The Screening program is funded by the Centers for Disease Control and administered by the local health departments or other contracted entities. Since DHMH determines eligibility, this coverage group is found on MMIS, not on CARES.

Aliens - X-Track

X01 Discontinued 12/1/09: State Funded Aliens – Children and Pregnant Women

Effective 12/1/2009, Maryland began operating under the 2009 federal law lifting the 5-year bar to Medicaid or CHIP eligibility that had been imposed on legal permanent residents (LPRs). The existing beneficiaries of the former state-funded program were transferred to appropriate P-track coverage groups, and the new Medicaid-eligible 19 and 20 year olds to F98. At the same time, the X01 group was closed to new applicants. Now pregnant women with income up to 250% FPL and children up to age 21 with income up to 200% FPL, who are LPRs or carry humanitarian visas, can qualify for federally matched MA services; and such children up to19 with incomes up to 300% FPL can qualify for CHIP services. *See* AT 10-14 (11/12/09).

The X01 coverage group has also been used for disaster assistance. Between September 1, 2005 and January 31, 2006, applications were taken under coverage group X01 from Hurricane Katrina evacuees. Before 11/1/05, such applicants were approved for a one-time-only certification period of 4 months. Individuals who applied on or after 11/1/05 were approved for a certification period of 5 months. They were covered for all Medical Assistance services on a fee-for-service basis. Federal claiming was done through a special waiver. (See FIA Action Transmittals 06-11 – 06-15 and 06-20.)

X02 Undocumented or Unqualified Immigrants – Emergency Medical Services

Federally matched Medical Assistance coverage for **emergency medical services** is provided to undocumented or unqualified immigrants who are technically (including Maryland residency) and financially eligible for MA FAC (F-track), ABD with or without spend-down (S98 or S99), or MCHP (P-track except for P13 and P14), except that they do not meet the citizenship or alien eligibility requirements. **A card is not issued** because this coverage is limited to payment for emergency medical services that have generally already been received. Eligibility is determined based on a professional review of medical records to evaluate if the services received were emergency services. Federally matched coverage for labor and delivery is also extended to undocumented or unqualified women under this emergency service provision. Pregnant women who are undocumented or unqualified are permitted to enroll early in their pregnancy as a convenience to hospitals, but payments made on their behalf are restricted to services with labor and delivery procedure codes.